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8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11
12 In the Matter of the Accusation Against:

13 **ALFREDO VILLAGRACIA RUIZ**
14 **9522 Carroll Canyon Road, #121**
San Diego, CA 92126

15 **Registered Nurse License No. 673160**

16 Respondent.

Case No. 2013-298

OAH Case No. 2012100758

A C C U S A T I O N

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about February 7, 2006, the Board of Registered Nursing issued Registered
24 Nurse License Number 673160 to Alfredo Villagrancia Ruiz (Respondent). The Registered Nurse
25 License was in full force and effect at all times relevant to the charges brought herein and will
26 expire on October 31, 2013, unless renewed. On November 13, 2012, pursuant to the Stipulated
27 Order for Interim Suspension of License Pursuant to Business and Professions Code Section 494,
28 Respondent's license was suspended.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 726 of the Code states:

The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3.

....

8. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

1 (1) Incompetence, or gross negligence in carrying out usual certified or
2 licensed nursing functions.

3

4 REGULATORY PROVISIONS

5 9. California Code of Regulations, title 16, section 1442, states:

6 As used in Section 2761 of the code, 'gross negligence' includes an extreme
7 departure from the standard of care which, under similar circumstances, would
8 have ordinarily been exercised by a competent registered nurse. Such an extreme
9 departure means the repeated failure to provide nursing care as required or failure
to provide care or to exercise ordinary precaution in a single situation which the
nurse knew, or should have known, could have jeopardized the client's health or
life.

10 10. California Code of Regulations, title 16, section 1443, states:

11 As used in Section 2761 of the code, 'incompetence' means the lack of
12 possession of or the failure to exercise that degree of learning, skill, care and
13 experience ordinarily possessed and exercised by a competent registered nurse as
described in Section 1443.5.

14 11. California Code of Regulations, title 16, section 1443.5 states:

15 A registered nurse shall be considered to be competent when he/she
16 consistently demonstrates the ability to transfer scientific knowledge from social,
17 biological and physical sciences in applying the nursing process, as follows:

18 (1) Formulates a nursing diagnosis through observation of the client's
19 physical condition and behavior, and through interpretation of information
obtained from the client and others, including the health team.

20 (2) Formulates a care plan, in collaboration with the client, which ensures
21 that direct and indirect nursing care services provide for the client's safety,
22 comfort, hygiene, and protection, and for disease prevention and restorative
measures.

23 (3) Performs skills essential to the kind of nursing action to be taken,
24 explains the health treatment to the client and family and teaches the client and
family how to care for the client's health needs.

25 (4) Delegates tasks to subordinates based on the legal scopes of practice of
26 the subordinates and on the preparation and capability needed in the tasks to be
delegated, and effectively supervises nursing care being given by subordinates.

27 (5) Evaluates the effectiveness of the care plan through observation of the
28 client's physical condition and behavior, signs and symptoms of illness, and

1 reactions to treatment and through communication with the client and health team
2 members, and modifies the plan as needed.

3 (6) Acts as the client's advocate, as circumstances require, by initiating
4 action to improve health care or to change decisions or activities which are against
5 the interests or wishes of the client, and by giving the client the opportunity to
6 make informed decisions about health care before it is provided.

7 **COST RECOVERY**

8 12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
9 administrative law judge to direct a licensee found to have committed a violation or violations of
10 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
11 enforcement of the case.

12 **FACTS**

13 **Golden Touch III**

14 13. In August 2010, Respondent was employed as a registered nurse at Golden Touch III,
15 a residential nursing care facility for the elderly, located in San Diego, and owned and operated
16 by registered nurse Russel T. On August 23, 2010, Respondent was in charge of providing
17 nursing care to the patients at Golden Touch III. On August 23, 2010, an investigator from the
18 California Department of Social Services inspected Golden Touch III. Upon inspection, the
19 inspector discovered that the conditions in the facility were unsafe and inappropriate in that the
20 temperature was too high, there were electrical problems, the staff in the facility could not
21 communicate in English, and two of the patients in the facility required a higher level of care than
22 what was being provided.

23 14. The investigator also discovered that Respondent had assumed the medical care of
24 two patients who required 24 hour skilled nursing or intermediate care, which were beyond the
25 capability and licensure of Golden Touch III. However, Respondent did not review the
26 physician's reports for either patient prior to assuming care. Respondent did not even know the
27 medical conditions of the two patients and he allowed a non-medical professional to provide
28 medical care, including trachea suction and G-tube feeding, to one of the patients. Respondent
also did not know where the diabetic supplies were located even though he was caring for a

1 patient who required diabetic care. Both patients were non-communicative and had to be
2 transported from the facility to a hospital by ambulance for appropriate care.

3 15. On September 4, 2012, the California Department of Social Services, Community
4 Care Licensing issued an *Order to Individual of Immediate Exclusion From Any Facility*
5 *Prohibited Positions or Employment*, prohibiting Respondent from being physically present or
6 employed by any facility licensed or certified under the jurisdiction of the Community Care
7 Licensing Division, or from having contact with clients in such a facility. The Order was based
8 on the determination that Respondent's "continued employment or future contact with clients or
9 presence in any child day care or residential facility licensed by the California Department of
10 Social Services constitutes a threat to the health and safety of the clients in care."

11 **Maria B.**

12 16. In or about early 2011, Respondent and another registered nurse, Russel T. were
13 employed as registered nurses by AMS Homecare Solutions. In February and March 2011,
14 Respondent and Nurse Russel were assigned to provide nursing care and treatment to Maria B.,
15 whose family contracted with AMS Homecare Solutions. In February 2011, Maria B., was a 98
16 year old disabled female patient, who required around the clock in-home medical care to treat a
17 number of debilitating medical problems, including a stroke that resulted in the immobility of her
18 right arm and leg, congestive heart failure, the need for a tracheotomy, and difficulty with
19 speaking. However, she retained many of her cognitive abilities, including an awareness of her
20 surroundings and recognition of family members.

21 17. In order to protect her property and ensure her safety, Maria B.'s family installed
22 several video surveillance cameras throughout the home in 2008. Maria B.'s grandson installed
23 two motion censored cameras in Maria B.'s bedroom, one camera which displayed close-up black
24 and white footage of Maria B.'s bed and nearby surroundings, and one camera that provided an
25 expanded view of the bedroom, which displayed colored footage. Both of the surveillance
26 cameras in Maria B.'s bedroom were maintained in proper working order and recorded the
27 activities of the nurses caring for Maria B.

1 18. The video surveillance cameras in Maria B.'s bedroom revealed that from February
2 27, 2011 to March 11, 2011, Respondent and Nurse Russel engaged in repeated lewd sexual acts
3 with each other in front of and next to Maria B. Specifically, Nurse Russel groped, fondled, and
4 stroked Respondent's genitals multiple times within close proximity to Maria B.'s bed on
5 February 27, 2011, February 28, 2011, March 3, 2011, March 4, 2011, March 8, 2011, March 9,
6 2011, March 10, 2011, and March 11, 2011. Maria B. was awake during many of these instances.

7 19. On March 3, 2011, Nurse Russel exposed Respondent's bare penis in Maria B.'s
8 presence. On March 3, 2011, Respondent entered Maria B.'s bedroom bare-chested and wore
9 only a towel in her bedroom. On March 3, 2011 and March 11, 2011, Respondent held Maria
10 B.'s hand while Nurse Russel groped and stroked Respondent's genitals. During one of those
11 incidents on March 11, 2011, Maria B. swatted her hand at Respondent and Nurse Russel, and
12 appeared to be distressed by Respondent's sexual misconduct.

13 20. The video surveillance footage also showed that Respondent provided minimal
14 nursing care to Maria B. and repeatedly ignored her. On more than one occasion, Respondent
15 slept, watched television, and used his cellular telephone, instead of caring for Maria B.

16 21. On March 4, 2011, Respondent and Nurse Russel bathed Maria B. in front of an open
17 window, exposing her nude body. On March 4, 2011, Respondent and Nurse Russel cleaned
18 Maria B.'s trachea tubing using unsterile conditions. On March 7, 2011, Respondent and Nurse
19 Russel covered Maria B.'s eyes for over thirty minutes and utilized a glove restraint on her left
20 hand, even though Maria B. did not have physician orders for restraints.

21 22. Approximately two weeks after Respondent and Nurse Russel began caring for Maria
22 B., Maria B.'s daughter received a report from a caregiver that Respondent and Nurse Russel had
23 closed Maria B.'s bedroom door during the night. Maria B.'s daughter then watched the
24 surveillance videos, depicting Respondent's sexual misconduct and lack of care for Maria B.
25 Maria B.'s daughter immediately contacted AMS and asked that Respondent and Nurse Russel do
26 not return to care for Maria B. and filed a complaint with the Board of Registered Nursing.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 23. Respondent is subject to disciplinary action for unprofessional conduct under section
4 2761(a)(1) of the Code in that Respondent was grossly negligent as follows:

5 a. Respondent repeatedly failed to provide nursing care to his patients at Golden Touch
6 III which, under similar circumstances, would have ordinarily been provided by a competent
7 registered nurse, when he failed to transfer or obtain physician orders to transfer patients who
8 needed a higher level of care than offered by Golden Touch III and when he failed to review
9 physician orders prior to assuming care for his patients, as is set forth in paragraphs 13 through 15
10 above, which are incorporated herein as though set forth in full.

11 b. Respondent repeatedly failed to provide care or exercise ordinary precaution which
12 he knew or should have known could have jeopardized Maria B.'s health, when he engaged in
13 sexual acts in front of Maria B., when he slept during his shift instead of caring for Maria B.,
14 when he failed to use an aseptic technique while working with Maria B.'s trach, and by covering
15 Maria B.'s eyes with a towel causing her distress, as is set forth in paragraphs 16 through 22
16 above, which are incorporated herein as though set forth in full.

17 **SECOND CAUSE FOR DISCIPLINE**

18 **(Incompetence)**

19 24. Respondent is subject to disciplinary action for unprofessional conduct under section
20 2761(a)(1) of the Code in that Respondent demonstrated incompetence as follows:

21 a. While providing nursing care to patients at Golden Touch III, Respondent failed to
22 exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a
23 competent registered nurse, when he failed to verify the medical conditions of two patients prior
24 to assuming care, when he failed to acquaint himself with the location of the diabetic supplies,
25 when he failed to transport two patients who required a higher level of care from Golden Touch
26 III and when he failed to intervene and act as their advocate on behalf of the patients, as is set
27 forth in paragraphs 13 through 15 above, which are incorporated herein as though set forth in full.
28

1 b. While caring for Maria B., Respondent failed to exercise the degree of learning, skill,
2 care and experience ordinarily possessed and exercised by a competent registered nurse, when he
3 failed to use aseptic technique while working with Maria B.'s trach, when he failed to close the
4 blinds while bathing Maria B.; when he slept, used his cellular telephone, and watched television;
5 and when he engaged in repeated sexual acts instead of caring for Maria B., as is set forth in
6 paragraphs 16 through 22 above, which are incorporated herein as though set forth in full.

7 **THIRD CAUSE FOR DISCIPLINE**

8 **(Sexual Misconduct)**

9 25. Respondent is subject to disciplinary action for unprofessional conduct under section
10 726 of the Code in that while on duty as a registered nurse, Respondent engaged in acts of sexual
11 misconduct when he repeatedly committed lewd sexual acts next to and in front of an elderly
12 patient, Maria B., as is set forth in paragraphs 16 through 22 above, which are incorporated herein
13 as though set forth in full.

14 **FOURTH CAUSE FOR DISCIPLINE**

15 **(Unprofessional Conduct)**

16 26. Respondent is subject to disciplinary action for unprofessional conduct under section
17 2761(a) of the Code in that while on duty as a registered nurse, Respondent engaged in
18 unprofessional conduct as follows:

19 a. At Golden Touch III, Respondent provided care and services to patients without the
20 appropriate information regarding their care needs, failed to acquaint himself with the location of
21 the diabetic supplies, and provided direct care to a patient with a tracheostomy and a feeding tube,
22 before reviewing physician orders for her care needs, as is set forth in paragraphs 13 through 15
23 above, which are incorporated herein as though set forth in full.

24 b. While Respondent was on duty as a registered nurse for Maria B., Respondent
25 repeatedly engaged in lewd sexual acts next to and in front of Maria B., entered her bedroom
26 dressed in a towel, failed to close the blinds while bathing Maria B., slept during his shift instead
27 of caring for Maria B., and used his cellular telephone and watched television instead of caring
28

1 for Maria B., as is set forth in paragraphs 16 through 22 above, which are incorporated herein as
2 though set forth in full.

3 **PRAYER**

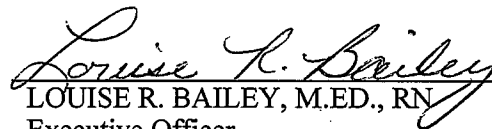
4 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
5 and that following the hearing, the Board of Registered Nursing issue a decision:

6 1. Revoking or suspending Registered Nurse License Number 673160, issued to Alfredo
7 Villagracia Ruiz;

8 2. Ordering Alfredo Villagracia Ruiz to pay the Board of Registered Nursing the
9 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
10 Professions Code section 125.3;

11 3. Taking such other and further action as deemed necessary and proper.

12 DATED: NOVEMBER 21, 2012

13 
14 LOUISE R. BAILEY, M.ED., RN
15 Executive Officer
16 Board of Registered Nursing
17 Department of Consumer Affairs
18 State of California
19 Complainant

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OAH SD

**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of the Petition For an Interim
Suspension Order Against:

Case No. 2013-298

OAH Case No. 2012100758

ALFREDO V. RUIZ
9522 Carroll Canyon Road, #121
San Diego, CA 92126

**STIPULATED ORDER FOR INTERIM
SUSPENSION OF LICENSE PURSUANT
TO BUSINESS & PROFESSIONS CODE
§494**

Registered Nurse License No. 673160

Respondent.

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this
proceeding that the following matters are true:

1. Louise R. Bailey, M.Ed., RN (Complainant and Petitioner) is the Executive Officer of
the Board of Registered Nursing. She brought this action solely in her official capacity and is
represented in this matter by Kamala D. Harris, Attorney General of the State of California, by
Nicole R. Trama, Deputy Attorney General.

2. Respondent Alfredo V. Ruiz, is represented in this proceeding by attorney Eric R.
Stene, Esq.;

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1 it will have on my Registered Nurse License. I enter into this Stipulated Order for Interim
2 Suspension of License voluntarily, knowingly, and intelligently, and agree to be bound by the
3 Order.

DATED:

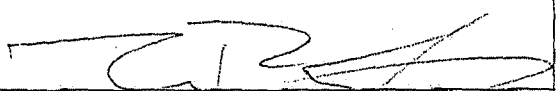
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ALFREDO V. RUIZ, Respondent

7 I have read and fully discussed with Respondent Alfredo V. Ruiz the terms and conditions
8 and other matters contained in this Stipulated Order for Interim Suspension of License. I approve
9 its form and content.

DATED:

11/13/12

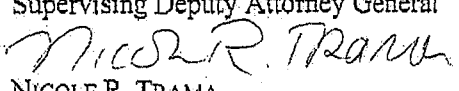

ERIC R. STENE, Attorney for RespondentENDORSEMENT

13 The foregoing Stipulated Order for Interim Suspension of License is hereby respectfully
14 submitted for consideration to the Office of Administrative Hearings.

DATED:

11/13/12

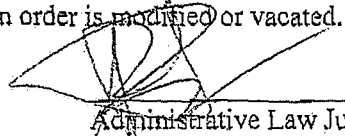
Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General

NICOLE R. TRAMA
Deputy Attorney General
Attorneys for Complainant

22 **IT IS SO ORDERED** pursuant to the above Stipulation that Respondent Alfredo V. Ruiz's
23 Registered Nurse License No. 673160 is suspended and Respondent Alfredo V. Ruiz is prohibited
24 from practicing registered nursing until a final decision on the Accusation in this matter becomes
25 effective, or until this interim suspension order is modified or vacated.

Dated:

Nov. 13, 2012


Administrative Law Judge
Office of Administrative Hearings

Alan R. Howard PALE

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**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of the Petition For an Interim
Suspension Order Against:

ALFREDO V. RUIZ

Registered Nurse License No. 673160

Respondent.

Case No. 2013-298

**INTERIM SUSPENSION ORDER
PURSUANT TO BUSINESS &
PROFESSIONS CODE § 494**

Date: October 24, 2012

Time: 1:30 p.m.

Place: Office of Administrative Hearings,
1350 Front Street, Suite 3005
San Diego, CA 92101

The Office of Administrative Hearings having presided over the above-entitled matter,
having reviewed and considered the Petition for Interim Suspension Order including the
Memorandum of Points and Authorities and the Declarations and Exhibits filed in support
thereof; Exhibits filed in support of respondent's opposition to the petition; and oral argument;

IT IS HEREBY ORDERED AND ADJUDGED THAT:

1. This is a proper case for the issuance of an interim order of suspension in that
permitting Respondent Alfredo V. Ruiz to continue to engage in the practice of nursing will
endanger the public health, safety, and welfare;
2. Serious injury will result to the public before the matter could be heard on
notice;
3. Therefore, pending further order from the Office of Administrative Hearings or
the Board of Registered Nursing, License No. 673160 issued to Alfredo V. Ruiz, shall be, and
hereby is immediately restricted as follows:
 - a. respondent shall not work for or perform any nursing services for a home health
agency;
 - b. respondent shall work for and perform nursing services only in a hospital;

1 c. respondent shall not work the same shift in the same hospital as Russel Olvena
2 Torralba;

3 d. respondent shall ensure that he does not work the same shift in the same
4 hospital as Russel Olvena Torralba; and

5 e. respondent shall notify his immediate supervisor before every shift he begins
6 that he is not permitted to work the same shift in the same hospital as Russel Olvena Torralba.

7 4. A copy of this Interim Order of Suspension shall be served on Respondent via
8 Overnight Mail Delivery Service, Certified Mail and First Class Mail at his address of record on
9 file with the Board of Registered Nursing.

10 **IT IS SO ORDERED** on this 24th day of October 2012.

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13 ALAN S. METH
14 ADMINISTRATIVE LAW JUDGE
15 OFFICE OF ADMINISTRATIVE HEARINGS
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